ABDUL RAZAK DATUK ABU SAMAH A

v.

RAJA BADRUL HISHAM RAJA ZEZEMAN SHAH & ORS

HIGH COURT MALAYA, KUALA LUMPUR B
VAZEER ALAM MYDIN MEERA JC
[CIVIL SUIT: 21NCVC-96-2011]
11 APRIL 2013

TORT: *Negligence - Professional negligence - Whether surgeon and anaesthetists negligent in management and treatment of patient - Whether inherent and material risks of surgery and anaesthesia explained to patient - Whether patient's consent to surgery obtained without her appreciation of risks involved - Whether patient's primary care doctor owed duty to explain nature and risks of surgery to patient's next of kin who was decision-maker* C D

TORT: *Negligence - Duty of care - Duty to inform risks involved in management and treatment of patient - Whether duty of care to explain nature and risks of surgery extended to next of kin - Whether patient relied on next of kin to make decision* E

This was a medical negligence suit by the plaintiff for damages against the defendants for causing the death of his wife ('the patient'). The first defendant ('Dr Badrul'), a colo rectal surgeon, was the doctor in charge of the patient. The second and third F defendants were consultant anaesthetists and the fifth defendant was a medical officer who had assisted the second and third defendants while surgery was performed on the patient by Dr Badrul. The first, second, third and fifth defendants were employed by the fourth defendant at the Hospital Kuala Lumpur G ('HKL'). The fourth defendant was sued for being vicariously liable for the negligence of the other defendants. The patient, aged 71, was initially admitted to the government hospital in Temerloh, Pahang, complaining of abdominal pain and vomiting. Since her condition did not improve after a week the plaintiff had her H transferred to HKL to be under the care of Dr Badrul whom the plaintiff knew personally. For the two days following the patient's admission, Dr Badrul was away attending a conference but he instructed his surgical trainee ('Dr Leong') to, among other things, insert a Ryle's tube into the patient's stomach *via* her nose to I pump out the build-up of stomach fluid caused by intestinal obstruction which was proved by a CT scan to be the patient's

A ailment. On the night his conference ended Dr Badrul decided the patient required urgent surgery the following day and he instructed Dr Leong to get the patient to sign the consent papers for surgery. Since he had been informed by his staff that the patient had refused to have the Ryle's tube inserted as it caused her
B discomfort and made her vomit, Dr Badrul requested the second defendant to attend to the insertion of the tube before performing surgery on the following morning. The second defendant was, however, unable to attend to the matter as she was called away to attend to another emergency case and she left the patient in
C the third defendant's care. On the morning before the surgery, Dr Badrul informed the patient of the immediate need for surgery. He also spoke to the plaintiff on the telephone about it and got his consent to proceed. Despite being strongly advised by the surgical team that she had to have the Ryle's tube inserted before
D anaesthesia was administered to prevent stomach contents from regurgitating and getting into her lungs, the patient adamantly refused the tube. The team finally decided to administer anaesthesia and insert the tube after she had passed out. However, while anaesthesia was being administered the patient
E regurgitated a large volume of stomach fluid which entered into her lungs causing respiratory failure that led to her death from aspiration pneumonia the following day. *Inter alia*, the plaintiff's case was that the relevant defendants: (i) failed to act in accordance with the standard of care expected of them by
F proceeding to administer anaesthesia without the Ryle's tube being in place despite being fully aware of the risks of doing so; and (ii) breached their duty of care owed to both the patient and the plaintiff by failing to explain to them before their consent was obtained, the risks associated with the surgery and anaesthesia
G particularly the risk of death due to aspiration of regurgitated stomach contents if the Ryle's tube was not inserted. The plaintiff contended that Dr Badrul, being the doctor in charge of the patient, should have himself attempted to insert the Ryle's tube instead of leaving that task to the nurses and his surgical trainee
H and that he should not have instructed Dr Leong to obtain the patient's consent to the surgery as there was no evidence that the trainee had properly advised her of the risks involved. The plaintiff also contended that Dr Badrul knew fully well that the plaintiff made the decisions with regards to the patient's medical treatment
I and therefore Dr Badrul should have informed him of her refusal to have the Ryle's tube inserted and the attendant risks involved so that he could have persuaded her to have the procedure done or even have called off the surgery. The defendants contended

that they did their best to advise and persuade the patient to have the Ryle's tube inserted and when all attempts failed they took the precautionary measures of administering anaesthesia using the Rapid Sequence Induction (RSI) technique while a trained nurse applied cricoid pressure on the patient to prevent or arrest regurgitation.

Held (allowing claim with costs against first, third, fourth and fifth defendants and dismissing claim against second defendant):

(1) The failure to stop the regurgitation of the stomach fluid did not mean the third and fifth defendants were negligent in their care or that they had not provided the necessary and acceptable standard of professional care. Based on the expert medical testimony, regurgitation and aspiration could occur especially in cases of intestinal obstruction whether or not a Ryle's tube was inserted or cricoid pressure applied. (para 32)

(2) The medical experts agreed that while insertion of the Ryle's tube could mitigate against the risk of aspiration of stomach contents by removing some amount of it before surgery, the presence of a Ryle's tube was not mandatory prior to the induction of anaesthesia and its presence did not guarantee an empty stomach nor did it eliminate the risk of aspiration altogether. (paras 17 & 33)

(3) In the light of the evidence and current medical practice, non-insertion of the Ryle's tube prior to induction of anaesthesia was acceptable medical practice so long as the medical team was prepared for the eventuality of aspiration as was the case here. The third and fifth defendants had taken all necessary precaution and preparation to anticipate regurgitation. They had used the RSI technique for anesthesia while a trained anesthetic nurse applied cricoid pressure. (paras 36 & 31)

(4) The first, third and fifth defendants breached their duty of care to the patient in failing to inform and advise her adequately and sufficiently of the inherent and material risks – particularly of death due to aspiration – of proceeding with the surgery and anaesthesia without insertion of the Ryle's tube. The patient had consented to the surgery and anaesthesia without having appreciated the grave risks involved. (para 44)

(5) Even though the consent form did not require the plaintiff's consent to the surgery, the factual matrix of the case indicated that the first defendant had a duty to inform the plaintiff of the nature of the surgery and the inherent and material risks of the procedure especially in view of the patient's refusal to have the Ryle's tube inserted. It was clear from the evidence that the patient depended on the plaintiff to make the decision to proceed with immediate surgery. (para 46)

(6) There was insufficient evidence to establish negligence against the second defendant. She had a very limited role in the care of the patient and in the medical decisions that were taken. The plaintiff had proved negligence against the first, third and fifth defendants and, by virtue of that, the fourth defendant was vicariously liable for their negligence. (paras 47 & 49)

Case(s) referred to:

Bolam v. Friern Hospital Management Committee [1957] 2 All ER 118 ***(refd)***

Foo Fio Na v. Dr Soo Fook Mun & Anor [2007] 1 CLJ 229 FC ***(refd)***

Gurmit Kaur Jaswant Singh v. Tung Shin Hospital & Anor [2013] 1 CLJ 699 HC ***(foll)***

Mathew Scott Oakley & Ors v. Dr George Varughese & Anor [2010] 10 CLJ 322 HC ***(refd)***

Roe v. Minister of Health [1954] 2 QB 66 ***(refd)***

Rogers v. Whitaker [1992] 175 CLR 479 ***(refd)***

Wu Siew Yong v. Pulau Pinang Clinic Sdn Bhd & Anor [2011] 1 CLJ 255 HC ***(refd)***

For the plaintiff - Ambiga Sreenevasan (James Khong & Joanne Leong with her); M/s James Khong

For the defendants - Lee Boon Koon; FC

Reported by Ashok Kumar

JUDGMENT

Vazeer Alam Mydin Meera JC:

[1] This is an action for damages brought against the defendants for professional negligence in the management and treatment of the plaintiff's late wife Fatimah @ Rohani binti Zainal ('the patient') at the Kuala Lumpur Hospital ('HKL'). The first defendant is a colorectal surgeon who as the patient's primary doctor and caregiver performed a surgical procedure on the

patient, that is the subject matter of this suit. The second and third defendants are consultant anesthetists, whilst the fifth defendant an anesthetic Medical Officer assisted the second and third defendants in the operating theatre during the surgery. The first to third and the fifth defendants were at the material time employed by the fourth defendant and attached to HKL.

[2] The patient then aged 71 was admitted to Hospital Sultan Haji Ahmad, Temerloh, Pahang, on 21 May 2010 following abdominal pain and vomiting. At the Temerloh Hospital the patient was diagnosed with adhesion colic and treated conservatively with medication and intravenous ("IV") fluids. As her condition did not improve, the patient was upon the plaintiff's request transferred to HKL on 28 May 2010 under the primary care of the first defendant.

[3] The plaintiff spoke to the first defendant and the first defendant agreed to treat the patient. The plaintiff had specifically arranged for the first defendant to treat the patient, as he knew the first defendant personally, having been previously treated by the first defendant professionally. The first defendant had also assessed the patient's condition by speaking to her doctors at the Temerloh Hospital.

[4] Upon admission at HKL, the patient was initially treated conservatively. A day after admission, the patient was referred to the first defendant's surgical department and was then examined, managed and cared for by a surgical team. The first defendant was attending a conference in Malacca on 29 May 2010 and 30 May 2010 and did not personally attend to the patient on these dates. It is the first defendant's evidence that whilst he was away his surgical trainee one Dr. Leong Ai Chen ("Dr Leong") contacted him on the phone to report on the general medical condition of the patient from time to time. The first defendant instructed Dr Leong to investigate the patient for intestinal obstruction; to keep the patient fasting; and to insert an IV drip as well as a Ryle's tube. A Ryle's tube is inserted to the stomach through the nostril and esophagus. The purpose of a Ryle's tube is to pump out stomach fluid and ease the pain and discomfort associated with intestinal obstruction.

[5] Further, upon the first defendant's orders and as part of the investigative procedure, an urgent CT scan was done on 29 May 2010. The CT scan revealed that the patient was having small bowel obstruction secondary to adhesion. According to the first

defendant, on the night of 30 May 2010, based on his telephone communication with the surgical team at HKL, he had formed the view that the patient would require surgery. He had then ordered his surgical trainee to prepare the patient for surgery the next morning.

[6] On the morning of 31 May 2010, that is three days after the patient was admitted to HKL, the first defendant decided definitively that an urgent surgery had to be done the very day. The first defendant then discussed the proposed surgery with the patient. The patient then called the plaintiff on the telephone and asked the first defendant to speak to the plaintiff. In this regard, the plaintiff in answer to question 5 of his witness statement ("PWS1") said that:

> On the morning of 31.5.2010, I was at home preparing to visit my wife when I received a telephone call from her. She told me that Raja Badrul wanted to speak to me. Over the telephone, Raja Badrul informed me that he had to operate on my wife that very day. I agreed to the operation.

According to the plaintiff, that was all the first defendant said to him and the plaintiff abided by the first defendant's decision and recommendation.

[7] The plaintiff states that not knowing when the surgery was to be undertaken, he arrived at HKL sometime about noon on 31 May 2010. He waited for the patient at the ward, where no one spoke to him. It was only in the evening that the plaintiff found out that the operation was over and that the patient was warded in the Intensive Care Unit. The first defendant came to see the plaintiff and informed him that he had successfully carried out the surgery.

[8] However, the second defendant had painted a different picture. According to the second defendant, the patient had refused insertion of the Ryle's tube before induction of anesthesia. The second defendant also informed the plaintiff that during induction of anesthesia the patient had regurgitated large amount of stomach fluid that had entered into the patient's lungs, which had caused problems. The patient's condition deteriorated two hours into the operation. And was attended to by the third and fifth defendants. The second defendant informed the plaintiff that the patient's post operative condition was very critical. Having

heard the second defendant's assessment of the patient's condition, the first defendant then admitted to the plaintiff that he could have done better.

[9] The patient passed away on 1 June 2010 from aspiration pneumonia occasioned from damage caused to her lungs and airways from aspiration of stomach fluid during induction of anesthesia.

[10] Though the plaintiff has raised various issues in his pleadings, during closing arguments counsel for the plaintiff has confined the claim to the following issues:

(a) whether in the circumstance of this case, the first, second, third and/or fifth defendants had, in the treatment of the patient, acted in accordance with the standard of care expected of the first, second, third and/or fifth defendants, particularly as regards to whether the said defendants ought to have inserted a Ryle's tube prior to induction of anesthesia;

(b) whether the death of the patient can be said in law to have been negligently caused or materially contributed by the first, second, third and/or fifth defendants in breach of their respective duties of care owed to the patient;

(c) whether in the circumstance the fourth defendant is vicariously liable for the negligence of the first, second, third and/or fifth defendants;

(d) whether in the circumstance of this case, the defendants had breached their duty of care owed to the plaintiff by failing, refusing and/or neglecting to advise or explain to the patient and/or plaintiff prior to the surgery the risks associated with the proposed surgery and in particular the taking of the patient's consent as well as the procedures necessary therefore or the urgency for the same;

(e) whether in the circumstance of this case, the defendants had breached their duty of care owed to the plaintiff by failing, refusing and/or neglecting to obtain the necessary prior consent from the plaintiff to proceed with surgery or any procedure in connection to or leading to the surgery on 31 May 2010;

(f) whether in the circumstance, the plaintiff is entitled to damages, interest and cost as pleaded in the statement of claim.

[11] During the course of the trial, the following witnesses testified:

PW1 : Abdul Razak bin Datuk Abu Samah, the plaintiff;

PW2 : Dr Kattayat Mohandas, Consultant Anesthesiologist - the plaintiff's expert witness;

DW1: Dr Raja Badrul Hisham bin Raja Zezeman Shah - the first defendant;

DW2: Dr Rushin a/l Maria - the fifth defendant;

DW3: Siti Rokiah binti Osman - staff nurse at HKL;

DW4: Kamalia binti Hussin - staff nurse at HKL;

DW5: Dr Azrin bin Mohd Azidin - the third defendant;

DW6: Dr Raja Jasminaz binti Raja Jamaludin - the second defendant;

DW7: Dr Lim Wee Leong - Senior Consultant Anesthesiologist at Sungai Buloh Hospital - the defendants' expert witness;

DW8: Nurilah Othman, nurse at HKL; and

DW9: Mazni binti Ahmad - nurse at HKL.

[12] It is well settled that the plaintiff bears the burden of proof in cases of this nature. It is the plaintiff's burden to prove negligence against the defendants on the basis that what was done was what a reasonably competent practitioner skilled in that particular art would have done or would not have done. (See *Wu Siew Yong v. Pulau Pinang Clinic Sdn Bhd & Anor* [2011] 1 CLJ 255 and *Mathew Scott Oakley & Ors v. Dr George Varughese & Anor* [2010] 10 CLJ 322).

[13] On the issue of standard of care in medical negligence, the Federal Court in *Foo Fio Na v. Dr Soo Fook Mun & Anor* [2007] 1 CLJ 229 departed from the decades old principle laid down in *Bolam v. Friern Hospital Management Committee* [1957] 2 All ER 118 and applied up till then in the Malaysian courts and adopted the test laid down in the Australian case of *Rogers v. Whitaker* [1992] 175 CLR 479. The Federal Court held that the standard of care is not determined solely or even primarily by reference to the practice followed or supported by a reasonable body of medical opinion ('the *Bolam* test'). On the contrary it is "for the court to determine what the reasonable doctor would have done, not the

profession. What the profession does in a given situation will be an important indicator of what ought to have been done, but it should not necessarily be determinative. In the final analysis, the court should set the standard of care in negligence, drawing upon the evidence presented". (See p. 257 of the judgment of the Federal Court).

[14] Even though the question of reasonable standard of care is a question for the court's determination, evidence of accepted medical practice is still a useful guide for courts to formulate their conclusion. This was expressly recognised by the Australian High Court in *Rogers v. Whitaker* (*supra*). This principle has been followed by my brother Justice Harmindar Singh Dhaliwal in *Mathew Scott Oakley* (*supra*) where he held that:

> In the case of diagnosis and treatment, the court would have to rely on expert opinion. Standards and practices generally accepted by distinguished members of the medical profession will normally be decisive. In *Bolitho*, Lord Browne Wilkinson reiterated (at p. 779):
>
> > I emphasise that, in my view, it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes clear, it would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the bench mark by reference to which the defendant's conduct falls to be assessed.

Now, that is the law as it stands on the standard of care required of medical professionals when it relates to diagnosis and treatment. I will now analyse the evidence in light of the legal principles enunciated above.

[15] The parties are in agreement as to the cause of the patient's death. She had aspirated during anesthesia (regurgitation of stomach content into the respiratory system) causing respiratory failure that ultimately led to her demise from aspiration pneumonia.

[16] Both expert witnesses (PW2 and DW7) are also in agreement that:

(i) aspiration may occur at the point or at any point after the patient loses consciousness during anesthesia;

(ii) massive aspiration of very acidic stomach content is highly likely to cause severe damage to the respiratory system;

(iii) such aspiration could cause death; and

(iv) very little could be done to effectively address or reverse the effects of aspiration once stomach content have entered into the lungs.

[17] The experts and the first, second and third defendants agree that in order to reduce the risk of aspiration, pumping out stomach fluid before surgery by the insertion of a Ryle's tube through the nasal cavity of a patient is a recognised and recommended medical technique. However, they also agree that the insertion of a Ryle's tube may not necessarily eliminate the risks of aspiration completely; but it serves to mitigate such risks by removing some amount of stomach content before an operation. As such it would be prudent medical practice that in all surgical cases involving intestinal obstruction a Ryle's tube is inserted prior to an operation. It is precisely for this reason that the first defendant had given instructions for the insertion of the Ryle's tube when the patient was first admitted into HKL. The first defendant gave evidence to the effect that he appreciated the importance of Ryle's tube insertion before the operation and gave repeated instructions for the Ryle's tube insertion to be performed in the ward. The second defendant in her testimony during cross-examination had acknowledged the importance of the Ryle's tube and in the circumstance what she would have done in the following terms:

> Counsel (P) : Now, here you say in your answer that you were the Anesthetist on call that day, and you were in charge of this particular patient and you received a call from Dr Raja Badrul. You then proceeded in your answer to say that there is a plan and you call it "the plan" in your answer. What is this plan?

Second defendant : Dr Raja Badrul informed me that he has put up this case for surgery some time in the mid-morning. I don't remember the time and then he informed me that this patient does not have a Ryle's tube in the ward. It was a brief discussion. I said, "Why is it that she doesn't have a Ryle's tube?" He said "Patient refused" and then his word was that "Can you do something about it?" At that point I can only take it that I will address the issue of her not having the Ryle's tube in the operating theatre. It's unreasonable if he were to expect me to go to the ward and address this issue of her not having the Ryle's tube. I was the On-Call Anesthetist and in HKL at any one time, I was supervising six to seven theatres at that point in time. So you cannot be expecting me to go to the ward. So I just tell him yes, we'll call the patient when she is ready and take it from there. So my own plan was that I would try to attempt putting the Ryle's tube before inducing her.

Counsel (P) : I sense that you at the time probably felt quite strongly about the Ryle's tube. Why did you have these feelings that you know, we need to deal with the Ryle's tube?

Second defendant : Well, this is a case of intestinal obstruction. From undergraduate days, from houseman days, you know it's a part of management of intestinal obstruction. So the fact that she has been in the ward and not having a Ryle's tube is something peculiar.

Counsel (P) : You came to the conclusion that this patient needed a Ryle's tube and you intended to insert the Ryle's tube later, is that correct?

Second defendant : I would. My intention was to address the issues when she arrives in the theatre.

However, the patient had steadfastly refused the Ryle's tube insertion because it was very uncomfortable and made her vomit. The first, third and fifth defendants as well as the nurses (DW3, DW4, DW8 and DW9) confirmed this in their testimony. The patient's refusal to have the Ryle's tube insertion is also recorded

in the patient's hospital records tendered in evidence. The patient had also refused the Ryle's tube insertion when she was at the Temerloh Hospital. The first defendant's evidence in this regard is found in his witness statement (DWS1):

> Q21 : Did she have a Ryle's Tube prior to the operation?
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> A21 : No, she did not.
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> Q22 : Why?
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> A22 : She refused for the insertion of the tube despite several attempts.
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> Q23 : Did you advise Madam Fatimah regarding the insertion of Ryle's Tube?
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> A23 : Yes, I did. I informed her that the Ryle's tube would be uncomfortable but we would try to put it in gently. This was in the morning of the day that she was informed about the emergency surgery. She was obviously distressed by the news that she would have to undergo an emergency surgery with all the possible complications. I finally decided that I did not want to cause her further distress and informed her that perhaps the Ryle's tube could be inserted when she is already in the operation theatre, prior to starting the surgery.

[18] The first defendant states in his testimony that he recognised the potential complication that the patient could have without the Ryle's tube and that is why he called the second defendant to address the issue at the operation theatre with the patient. However, before she could attend to it, the second defendant was called away to attend to another emergency case and the patient was left in the care of the third defendant - in so far as anesthesia was concerned. The fifth defendant addressed the issue of the Ryle's tube with the patient at the recovery area of the operating theatre prior to induction of anesthesia. The fifth defendant, who was the Medical Officer assisting the third defendant, says that he had explained to the patient that because she was having intestinal obstruction, a Ryle's tube needed to be inserted to drain out the gastric content to reduce the risk of aspiration when she loses consciousness. However, according to the fifth defendant, the patient refused and said that she would only allow the Ryle's tube to be inserted after she was under general anesthesia.

[19] The fifth defendant then informed the third defendant that the patient had refused the Ryle's tube insertion. The fifth defendant also states that he had counselled the patient on the importance of the Ryle's tube; but the patient was steadfast in her refusal and asked for its insertion to be done after she had lost consciousness following induction of anesthesia. Then a decision was taken to do just that. The consequence was that the patient regurgitated large volume of highly acidic stomach content that entered into the patient's respiratory system and caused damage to her lungs and ultimately her death. This was despite the anesthetic team taking all appropriate measures to be prepared for any event of regurgitation or aspiration.

[20] The plaintiff's position is that against the unequivocal evidence of the importance of the Ryle's tube, the first, second, third and fifth defendant had failed to have it inserted and that this is not consonant with the standard of care. The plaintiff submits that the first defendant knew that there was a real risk that the patient would aspirate if she underwent anesthesia before removal of her stomach content, yet he did not ensure that this was done before induction of anesthesia. The plaintiff complains that the first defendant could have spoken to him about the patient's refusal and that he could have persuaded the patient to have the Ryle's tube inserted. The plaintiff's counsel submits that there is no evidence of the first defendant:

(i) informing the patient that it was vitally important to have the Ryle's tube inserted to prevent aspiration;

(ii) ensuring that the patient appreciated the importance and need for the Ryle's tube insertion and that it could possibly save her life;

(iii) assuring the patient that he could supervise the Ryle's tube insertion if she wished to have him present during such insertion;

(iv) neither did he tell that he could make the insertion himself and that he would do so gently and as painlessly as he reasonably could.

[21] In short, the plaintiff argues that the first defendant did not make any attempts to allay her fear or concerns of pain and no effort was made to make her as comfortable as he possibly could

for the insertion of the Ryle's tube. Therefore, the plaintiff submits that it is wholly conceivable that the patient refused the suggestions to have the Ryle's tube insertion as she had a preconceived notion from experience that it would be painful and uncomfortable. The plaintiff submits that:

(i) the first defendant merely left the insertion of the Ryle's tube to the nurses and surgical trainee without himself attempting to perform the procedure;

(ii) the second defendant did not even see or assess the patient before passing on her on to the third defendant's care. The second defendant mere communicated to the third defendant the little that was said to her by the first defendant;

(iii) the third and fifth defendants also had failed to insert the Ryle's tube despite having known that it would be required to be done before the operation and further knowing that the patient had vomited about 20 times that day and therefore it was reasonably foreseeable that she would regurgitate when she loses consciousness.

[22] Thus, the plaintiff argues that the first, second, third and fifth defendants had simply not done enough to ensure that the Ryle's tube was inserted. The plaintiff's case is that if this procedure had been done, it would have greatly reduced the chances of aspiration and possibly prevented her death. In the circumstance, the plaintiff's position is that the first, second, third and fifth defendants were negligent and had breached their duties in failing to provide reasonable care to the patient in not ensuring that a Ryle's tube was inserted to remove and/or reduce her stomach content when the patient was under their care.

[23] The defendants on the other hand say that the patient had persistently refused to have the Ryle's tube inserted even after having been counselled about the risk of aspiration. The fifth defendant in his evidence states as follows:

> Dr Azrin came down and we went to see her again in the Recovery Area and Dr Azrin explained to her that if she didn't have a Ryle's Tube, she was at high risk of aspiration when she was given anesthesia and loses consciousness. He also explained that the gastric contents would enter the lungs and damage the lung tissue and cause lung damage eventually.

The nurses who attended to the patient also gave evidence to the effect that the patient had persistently refused all attempts to insert the Ryle's tube.

[24] The defendants say that they have done all that they possibly could in the face of the patient's continuous refusal and her firm desire to have it inserted only after she had lost consciousness in the operating theatre. The defendants argue that surgery to address the patient's primary problem of intestinal obstruction had to be done on an emergency basis. The defendant's state that it would not have been wise to wait longer as the patient's adhesion colic could deteriorate and be life threatening. The defendants content that while it would have been best if there was a Ryle's tube prior to the operation, the refusal of the patient meant that they had to go ahead with anesthetic induction without the Ryle's tube and have it inserted immediately after induction. The third and fifth defendants had also taken all necessary precaution and preparation to anticipate regurgitation. The third defendant used the Rapid Sequence Induction ("RSI") technique for anesthesia. The fifth defendant assisted the third defendant in the inducing of anesthesia. Both the medical experts (PW2 and DW7) agree that the RSI is the accepted technique in such cases. The third defendant had a trained anesthetic nurse (DW3) on stand by to apply cricoid pressure on the patient should the need arise. The application of cricoid pressure is a technique used during anesthesia to prevent and/or arrest regurgitation of stomach fluid and its aspiration into the respiratory system. In fact DW3 did immediately apply cricoid pressure when the patient started to regurgitate unusually large amount of stomach fluid. Despite these efforts, the patient aspirated. Both experts are in agreement that regurgitation and aspiration can occur even if cricoid pressure is applied. The application of cricoid pressure is not a full proof method to stop aspiration.

[25] Both experts also agree that the presence of Ryle's tube is not mandatory prior to the induction of anesthesia and that its presence does not guarantee an empty stomach nor does it eliminate the risk of aspiration altogether. In fact the plaintiff's expert (PW2) had said that there are instances where anesthesia is administered without Ryle's tube even when it is indicated. PW2 said as follows:

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> But we do, as having said that, they do have patients put down without Ryle's tube. But we can't hold him against or in favour of that practice because there are other risks associated from not having a Ryle's tube ... If she still refuses, then we'll have to take the next step of having a patient on my hand now, full stomach, no Ryle's tube, I'll be prepared.

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[26] The defendant's expert witness DW7 has expressed similar view. He said that it is accepted anesthetic practice to proceed with induction of anesthesia without first inserting a Ryle's tube in an at-risk-of-aspiration patient. The first defendant in his C testimony said that in patients with intestinal obstruction, the risk of aspiration is always there regardless of whether there is a Ryle's tube or not. In fact, the first defendant says that he has had cases where intestinal obstruction patients have died from aspiration pneumonia even with Ryle's tube inserted. Both the D experts do not seem to have divergent views on this. Though the risk of aspiration could be reduced if the Ryle's tube had been inserted and stomach contents drained, that does not mean that the risk of aspiration can be totally eliminated. DW7 says that the risk of aspiration is significant in cases of intestinal obstruction E with or without Ryle's tube.

[27] My findings on the issue of the non-insertion of the Ryle's tube prior to induction of anesthesia is as follows. The plaintiff argues that the first, second, third and fifth defendants had simply F not done enough to ensure that the Ryle's tube was inserted to remove and/or reduce her stomach content when the patient was under their care. The plaintiff's case is that if this procedure had been done, it would have greatly reduced the chances of aspiration and possibly prevented her death. In the circumstance, the G plaintiff's position is that the first, second, third and fifth defendants were negligent and had breached their duties in failing to provide reasonable care to the patient.

[28] The defendants on the other hand say that the patient had H persistently refused to have the Ryle's tube inserted even after having been counselled about the risk of aspiration. The fifth defendant in his evidence states as follows:

> Dr Azrin came down and we went to see her again in the Recovery Area and Dr Azrin explained to her that if she didn't I have a Ryle's Tube, she was at high risk of aspiration when she was given anesthesia and loses consciousness. He also explained that the gastric contents would enter the lungs and damage the lung tissue and cause lung damage eventually.

The nurses who attended to the patient also gave evidence to the effect that the patient had persistently refused all attempts to insert the Ryle's tube.

[29] The defendants say that they have done all that they possibly could in the face of the patient's continuous refusal and her firm desire to have it inserted only after she had lost consciousness in the operating theatre. The defendants argue that surgery needed to be done on the patient on an emergency case basis. Neither the plaintiff nor his expert witness (PW2) challenged this prognosis.

[30] I accept the defendant's evidence that it would not have been wise to wait any longer to perform the surgery as the patient's adhesion colic could deteriorate and be life threatening. I also accept the defendants' contention that while it would have been best if there was a Ryle's tube inserted prior to the operation, the persistent refusal of the patient meant that they had to go ahead with anesthetic induction without the Ryle's tube and have it inserted immediately upon the patient losing consciousness.

[31] In this regard, I find that the third and fifth defendants had also taken all necessary precaution and preparation to anticipate regurgitation. The third defendant had used the RSI technique for anesthesia, which is the accepted technique for induction of anesthesia in such cases and he had a trained anesthetic nurse (DW3) on stand by to apply cricoid pressure on the patient should the need arise. I accept the evidence of DW3 that she applied cricoid pressure when the patient started to regurgitate. However despite her efforts, the patient aspirated.

[32] The failure to stop the regurgitation of stomach fluid does not mean that the third and fifth defendants were negligent in their care or had not provided the necessary and acceptable standard of professional care. I say so on the basis of the evidence of both experts that regurgitation and aspiration can occur even if cricoid pressure is applied. Therefore, the danger of aspiration is always there whether or not a Ryle's tube is inserted or cricoid pressure applied.

[33] In fact, both experts also agree that the presence of a Ryle's tube is not mandatory prior to the induction of anesthesia and that its presence does not guarantee an empty stomach nor does

A it eliminate the risk of aspiration altogether. In fact the plaintiff's expert (PW2) had said that there are instances where anesthesia is administered without Ryle's tube even when it is indicated. PW2 said as follows:

B > But we do, as having said that, they do have patients put down without Ryle's tube. But we can't hold him against or in favour of that practice because there are other risks associated from not having a Ryle's tube ... If she still refuses, then we'll have to take the next step of having a patient on my hand now, full stomach, no Ryle's tube, I'll be prepared.

C

[34] The defendant's expert witness DW7 has expressed similar view. He said that it is accepted anesthetic practice to proceed with induction of anesthesia without first inserting a Ryle's tube in an at-risk-of-aspiration patient. The first defendant in his D testimony said that in patients with intestinal obstruction, the risk of aspiration is always there regardless of whether there is a Ryle's tube or not. In fact, the first defendant says that he has had cases where intestinal obstruction patients have died from aspiration pneumonia even with Ryle's tube inserted. This evidence E stands unchallenged.

[35] Though the risk of aspiration could be reduced if the Ryle's tube had been inserted and stomach contents drained, that does not mean that the risk of aspiration can be totally eliminated. F DW7 says that the risk of aspiration is significant in cases of intestinal obstruction with or without Ryle's tube.

[36] I find that in light of the above evidence and current medical practice, the non-insertion of the Ryle's tube prior to induction of anesthesia is acceptable medical practice, so long as the medical G team is prepared for possible eventuality of aspiration, as was the case here.

[37] On the issue of whether proper consent was obtained from the patient and whether the patient ought to have been informed H of the risk of death from aspiration it is the plaintiff's submission that the defendants did not obtain proper consent from the patient in relation to the surgery for the following reasons:

(a) the patient was not informed by any of the defendants about I the possible fatal consequence of anesthetic induction without a Ryle's tube inserted and her stomach content emptied or

reduced prior to induction. Aspiration causing death and not just damage to her lungs was clearly a material and inherent risk specific to the patient's then prevailing medical condition;

(b) as a result of the induction without a Ryle's tube, she had aspirated and died of aspiration pneumonitis, a medical consequence which was entirely foreseeable to the defendants from the very beginning;

(c) the first defendant decided to proceed with surgery on the very day he had formed a definite opinion that surgery was necessary without having first discussed the same with the plaintiff and inform him of the possible risks and consequences.

[38] According to the plaintiff, the patient would not make any decision to go ahead with surgery without first having discussed the same with him. The plaintiff in his testimony had stated that the first defendant had full and personal knowledge that the plaintiff was the one who made decisions with regards to the medical treatment of the patient. It was the plaintiff who had spoken to the first defendant before having the patient transferred from Temerloh Hospital to HKL. After the patient's admission and prior to the first defendant leaving for Malacca to attend a conference on 29 May 2010, the first defendant had a face-to-face discussion with the plaintiff as to the patient's medical condition and he had informed the plaintiff that he would investigate her condition further. The first defendant in his testimony confirms some this assertion by the plaintiff. This evidence can be seen at p. 196 of the transcribed notes of proceedings in the following terms.

> I have his telephone number, and he calls me intermittently and he actually called me for this patient to be transferred under my care, so it is only courteous for me to call him to inform him when the real decision was made for the wife to undergo the surgery.

[39] The first defendant asking the patient to call the plaintiff on the phone on the morning of the intended surgery and the first defendant speaking to the plaintiff informing him of his decision to perform the surgery on the patient further fortifies plaintiff's assertion in this regard. The fact of the matter is that in the said telephone conversation, the first defendant said nothing to the plaintiff about the inherent dangers or risks of proceeding with the

surgery without a Ryle's tube inserted. The first defendant had merely informed the plaintiff of the need for surgery and the conversation ended with the plaintiff agreeing to the surgery. In fact, the plaintiff did not think that the surgery had serious risks and he took his time to arrive at the hospital thinking that the surgery would proceed right after the telephone call. The plaintiff felt that there was no need to see his wife before she entered the operating theatre, as there was no cause for concern.

[40] There is also no record in the medical case notes to show that the patient had been advised of the inherent and/or material risks of proceeding with the surgery without having had a Ryle's tube inserted or without the stomach being emptied of its content. In fact, from the testimony of the first defendant, it is apparent that the patient's consent for the surgery as shown in the consent form (at p. 117 of bundle B) was not obtained by the first defendant but by his surgical trainee, Dr Leong on the night before the intended surgery. There is no witness to the signature of the patient on the consent form. The first defendant assumes that Dr Leong would have explained the inherent and material risks of the surgery but cannot be sure of that. In any event, Dr Leong was not called as a witness at trial. What is evident from the first defendant's testimony is that when the patient signed the consent form for surgery, she did so without any advice from the first defendant who was her primary doctor and she did so on the night before the first defendant had made a definite decision to proceed with surgery. The following testimony of the first defendant during cross-examination is pertinent to the issue:

Counsel	:	Would you agree or disagree that at the point she signed this consent form, she did not know she was undergoing a major operation?
First defendant	:	I would disagree because I do trust Dr Leong and I know her.
Counsel	:	I understand. But you don't know whether she did it, doctor.
First defendant	:	I wouldn't know for sure.
Counsel	:	You are assuming that she did.
First defendant	:	Yes, I had to. I have to assume.

Counsel : Yes. Now, I'm also putting it to you, doctor, that she only understood the importance, the nature of the operation on the morning when you visited her. And that is why she called her husband and asked you to speak to him.

First defendant : Yes.

[41] The plaintiff states that if there had been proper advice or warning from the first defendant, he would not have allowed the surgery to proceed, until the risk of aspiration from her stomach content had been attended to. In fact it was the plaintiff's evidence that:

> ... None of the doctors or anyone in Hospital Kuala Lumpur told me of the importance of clearing my wife's stomach content before the operation was conducted on her. I never knew at that time that her stomach content could enter her lung when she was put to sleep or during the operation. Raja Badrul being the doctor in charge should have informed me.

Further, the plaintiff states in his witness statement that:

> If I had known of such danger, I would not have allowed the operation to go on. I would have persuaded my wife to allow the doctors to insert the tube before the operation or before she was put to sleep. I would have insisted that the doctors not perform the operation until they have exhaustively attempted to insert the tube or employed other methods to remove her stomach contents. Had I known of the grave risks involved and had the hospital been unsuccessful in removing her stomach contents before the operation, I would have sought second opinion, changed doctors or hospital or sought treatment elsewhere. The fact of the matter is that I was never informed.

[42] The first defendant had also agreed that it was incumbent upon him to have explained to the plaintiff the material and inherent risks of the surgery in the following answers during cross-examination (pp. 236 to 237 of the notes of proceeding).

Counsel (P) : I am suggesting to you doctor, that the onus is on you to have explained it to him face to face. Do you agree with me or do you disagree?

First defendant : Yes.

Counsel (D) : Yes?

First defendant : Sorry, yes.

Further, at p. 257 of the notes of proceeding, the first defendant says in cross-examination:

Counsel (P)	:	So it would be natural, wouldn't it, in those circumstances, doctor, to have discussed her case with the next-of-kin, with the plaintiff?
First defendant	:	Yes.

[43] The first, third and fifth defendants have agreed in the course of their testimony that the patient was never informed nor counselled on the risk of death due to aspiration during induction of anesthesia especially when she had refused the insertion of the Ryle's tube. In fact when it was suggested to the third defendant that the patient ought to have been counselled in this regard, the third defendant after a long pause agreed with counsel's suggestion. In light of the third defendant's own admission that the patient ought to have been counselled specifically on the increased risk of death from aspiration if the Ryle's tube is not inserted, I find that it is incumbent upon the first, third and fifth defendants to have counselled the patient on the increased risk of aspiration and death from aspiration when undergoing the surgery without the prior insertion of the Ryle's tube and the emptying of the stomach content.

[44] The Federal Court in *Foo Fio Na*'s case had stated clearly that the medical practitioner is "duty bound by law to inform the patient who is capable of understanding and appreciating such information of the risk involved in any proposed treatment so as to enable the patient to make an election of whether to proceed with the proposed treatment with knowledge of the risks involved or decline to be subjected to such treatment". In so deciding, the Federal Court reasoned that even if express consent was given in consent forms, the issues to be considered are the risks involved in the medical procedure in question and whether the patient has been sufficiently warned of such risks.

[45] Here the failure of the first, third and fifth defendants to inform the patient of the risk of death from aspiration, in fact the increased risk of death because of her full stomach, means that the patient had not been informed of a critical risk factor that would have been necessary for her to take into consideration in making her decision to proceed with general anesthesia and surgery. I find that the first, third and fifth defendants have failed

to discharge their duty of care owed to the patient to duly to inform and advise the patient adequately and sufficiently of the inherent and material risks of proceeding with the surgery and anesthesia without the insertion of a Ryle's tube. The first, third and fifth defendants have deprived the patient of such material information and caused her to consent to the surgery and anesthesia without having her appreciate the grave risks involved in the same.

[46] On the issue of whether the first defendant owes a duty to the plaintiff to inform him of the inherent risks of the surgery and anesthesia my finding is as follows. Ordinarily, in a doctor patient relationship, the duty of care is owed only to the patient. However, there are exceptions to this general principle. One such exception arose in the case of *Gurmit Kaur Jaswant Singh v. Tung Shin Hospital & Anor* [2013] 1 CLJ 699; [2012] 4 MLJ 260 where the High Court held that the consent of the patient herself was insufficient as the consent of the husband was not obtained for a hysterectomy as required under the consent form. I can see the obvious logic for the husband's consent to be obtained in cases of hysterectomy as it involves the joint reproductive rights of husband and wife. In other instances, consent of the next of kin may also be required in situations where the patient is incapable of giving consent or incapable of understanding and appreciating the nature of the proposed treatment and the risk involved. Similarly, consent of the spouse may be required when it is evident that the patient is dependent on the spouse to make decisions in regards to the proposed medical treatment or when it is evident to the doctor that the decisions are being made jointly by both spouses in respect of the treatment for one of the spouses.

[47] Here, even though the consent form does not require the consent of the plaintiff, the factual matrix of the case indicates that the first defendant owed a duty to inform the plaintiff of the nature of the surgery and the inherent and materials risk of the procedure, especially in light of the patient's refusal to have the Ryle's tube inserted. The fact is that, it was the plaintiff who made the decision to have the patient transferred from Temerloh Hospital to HKL to be attended to by the first defendant and spoke to the first defendant about it. The first defendant knew of

this and the transfer took place only after the plaintiff had a telephone conversation with the first defendant. It is also an undisputed fact that the patient after being informed of the surgery by the first defendant had immediately called the plaintiff on the phone and had requested the first defendant to speak to the plaintiff about it. This clearly indicates the dependence of the patient on the plaintiff to make the decision to proceed with immediate surgery. The plaintiff in his evidence said that the first defendant had merely informed him that emergency surgery had to be performed on the patient without informing of the risks of the surgery. The plaintiff testified that had he been told of the risks or that the patient was refusing the Ryle's tube and the attended increased risks of anesthesia under such conditions he would not have agreed to allow the patient to undergo the surgery. The plaintiff said that he made all medical decisions relating to the patient and that the lack of such advise and information meant that he could not make an informed decision and that this has deprived him from taking a second opinion. The involvement of the plaintiff in the patient's decision making is obvious from the evidence. The first defendant said that he does not discuss such matters over the telephone, yet the first defendant did not request the plaintiff to see him in person and explain the material and inherent risks before proceeding with the surgery. In the circumstance, it would have been prudent for the first defendant to discuss the patient's medical condition and the proposed treatment and its material and inherent risk with the plaintiff before the surgery. In this regard, the first defendant admitted that he could have done better.

[48] In the circumstance, I find that the first, third and fifth defendants have breached the duty of care and the plaintiff has successfully proved negligence against these three defendants. In so far as the case against the second defendant is concerned, I find that she had a very limited role in the care of the patient and the medical decisions that were taken. There is insufficient evidence against second defendant to establish negligence. As such the claim against the second defendant is dismissed.

[49] The first, third, and fifth defendants are employees of the fourth defendant which owns and operates HKL through the Ministry of Health. The vicarious liability of a hospital for the

negligence of medical practitioners employed by the hospital is well stated by Lord Denning MR in *Roe v. Minister of Health* [1954] 2 QB 66 where he held:

> The hospital authorities are responsible for the whole of their staff, not only for the nurses and doctors but also for anesthetists and surgeons. It does not matter whether they are permanent or temporary, resident or visiting, whole or part time. The hospital authorities are responsible for all of them.

[50] Under the circumstance, the fourth defendant is vicariously liable for the negligence of the first, third and fourth defendants. In the premise, judgment was entered for the plaintiff against the first, third, fourth and fifth defendants for damages to be assessed and cost to be borne by the first, third, fourth and fifth defendants.